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The Arithmetic of Health Care

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Summary

There is a simple arithmetic to the rising costs of health care, just as there was to the growing deficits and debt of the 1980s and early 1990s. Health care costs are increasing at a faster rate than the revenue of any government, and other critical priorities are being underfunded in the scramble to cover those costs. Despite enormous investments of new money, Canada's health care performance lags behind that of other Western countries such as Sweden. Yet, attempts to change the system are constrained by an ideological debate in which new ideas are often branded as taking Canada down the road to Americanization, privatization or two-tiered health care.

Canadian governments need to make their health care systems more effective and affordable, and in doing so they should look to models beyond North America.

New ways to fund health care are also needed, to prevent costs from continually squeezing out funding for other government priorities like education. The provincial case that there is a fiscal imbalance between the responsibilities of the provinces and the revenue available to the federal government rests upon some debatable assumptions. Also, an analysis of the position of Quebec, the only provincial government to specify the amount of new money it is requesting from Ottawa, shows that the federal government would have to go into deficit to meet the province's funding demands.

In determining its level of investment in health care, the federal government should avoid travelling the road taken by the provinces: underfunding other priorities and returning to deficit. If Ottawa commits to an escalator — a fixed formula to increase federal funding — then its investment in health care should increase at the same rate as the federal revenue. A federal commitment to pay a fixed share of health care costs would lead to a disproportionate share of federal money being committed to health in terms of other federal priorities. Also, Canada's experience with federal-provincial cost sharing in the 1980s shows that it is bad public policy to have one level of government running a program like health care while another level is committed to paying a share of its costs with no power to administer the programs and ensure their cost-effectiveness.

Provinces are already raising taxes, fees or premiums to help cover the costs of health care. The question, then, is what an ideal revenue-raising measure should look like. It must be fair and it should be based on income or ability to pay. A fee should not be charged at the point of service, since this could deter people from seeking needed care, but should be charged annually. The amount charged should be related to the individual's use of the system. People need to take more responsibility for their own health care choices and have a greater sense of the costs of the system.

There is also the issue of intergenerational equity. The funding of health care through general tax revenues has led to underfunding of education and higher tuition fees and student debt for people who, in addition, have to pay interest on the public debt racked up for programs they do not benefit from. To expect the same young people to pay higher taxes for health services that they use less than older Canadians is to place a further fiscal burden on their generation. With shortages of educated, skilled workers looming in the next decade, governments will not fare well in the international competition for such people if they burden them with high tax loads for services they little use; hence the need to link revenue measures to pay for health care with use of the health care system.

If the original goals of medicare are to be preserved, the current health care system will have to be changed. In addition, new ways to pay for health care will have to be found so that other government priorities can be adequately funded. Health care may be Canadians' highest priority, but it is not their only priority.

Résumé

L'augmentation des coûts des soins de santé obéit à une arithmétique aussi simple que celle qui a fait bondir dette et déficits dans les années 1980 et au début des années 1990. Ces coûts augmentent tout simplement plus rapidement que les revenus des différents gouvernements, qui se voient dès lors contraints de combler l'écart en sabrant dans le financement d'autres missions de l'État. Or, malgré d'énormes investissements additionnels, la performance du système de santé canadien reste à la traîne de plusieurs pays occidentaux comme la Suède, et tout effort visant à le réformer se heurte à un débat idéologique qui tend à stigmatiser la plupart des idées nouvelles comme ouvrant nécessairement la voie à l'américanisation des soins de santé, à leur privatisation ou à la création d'un système à deux vitesses.

À terme, les gouvernements du pays devront pourtant améliorer l'efficacité du système et en réduire les coûts, et ils auraient intérêt pour ce faire à s'inspirer de modèles autres que nord-américains. Il leur faudra également trouver de nouveaux modes de financement pour que cessent les compressions répétées dans d'autres domaines clés comme l'éducation.

L'affirmation par les provinces qu'il existe un déséquilibre fiscal qui ferait en sorte qu'elles ne disposent pas des revenus nécessaires pour rencontrer leurs responsabilités, alors que le gouvernement fédéral dispose de plus de revenus, repose sur des hypothèses contestables. Un examen de la situation du Québec, seule province ayant chiffré combien d'argent frais elle réclame du gouvernement fédéral, montre que celui-ci renouerait avec les déficits s'il répondait à ces demandes de financement.

En déterminant le niveau d'investissement qu'il consacrera à la santé, Ottawa doit éviter la voie empruntée par les provinces : celle du sous-financement de programmes clés et du retour aux déficits. S'il adopte une formule fixe d'indexation pour accroître sa part de financement, l'augmentation devra progresser au même rythme que ses revenus. S'il finançait une proportion fixe des dépenses de santé, c'est une part disproportionnée des fonds fédéraux qui irait à la santé par rapport à d'autres priorités nationales. Rappelons en outre que l'expérience des années 1980 avec les programmes à frais partagés a montré qu'il est peu judicieux de confier la gestion d'un programme comme la santé à un ordre de gouvernement alors que l'autre s'est engagé à en partager les coûts mais sans disposer des pouvoirs nécessaires pour l'administrer et le rentabiliser.

Les provinces prélèvent déjà impôts, frais ou droits pour couvrir leurs dépenses de santé. La question est de savoir en quoi consisterait l'instrument idéal pour se procurer les revenus nécessaires. Il faut que ce soit une mesure

équitable fondée sur les revenus ou la capacité de payer. Aucuns frais ne doit toutefois être exigé au point de service, ce qui risquerait d'empêcher les citoyens d'accéder aux soins dont ils ont besoin. Ces frais devraient plutôt être exigés sur une base annuelle et prendre en considération l'utilisation réelle que chaque individu fait du système. Les gens doivent se responsabiliser quant à leur propre santé et prendre conscience des coûts du système.

Il faut enfin considérer la question de l'équité intergénérationnelle. Le financement des soins de santé par l'impôt sur le revenu a entraîné le sous-financement de l'éducation, l'augmentation des droits de scolarité et l'endettement des étudiants, lesquels paient des intérêts sur une dette publique induite par des programmes dont ils ne profitent pas. En soutirant à la jeune génération plus d'impôt pour des soins dont elle fait un moindre usage que les Canadiens âgés, on alourdit encore le fardeau fiscal qu'elle doit supporter. À l'heure où l'on s'inquiète pour la décennie à venir d'une pénurie de travailleurs qualifiés et compétents, nos gouvernements risquent de mal réussir dans la compétition internationale pour les attirer s'ils les écrasent sous des impôts excessifs pour financer des services qu'ils utilisent peu. D'où la nécessité de lier à l'usage effectif du système de santé toute mesure visant à le financer.

Pour préserver les objectifs initiaux de l'assurance-maladie, il faudra tôt ou tard réformer le système de santé actuel. Il faudra aussi imaginer de nouvelles façons de couvrir les dépenses de santé pour assurer le financement adéquat d'autres programmes essentiels. La santé est certes la priorité numéro un des Canadiens, mais elle n'est pas leur unique priorité.

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Janice MacKinnon

Introduction

There is a simple arithmetic to the rate of increase in government health care costs, just as there was an inescapable arithmetic to the growing deficits and debt of the 1980s and 1990s. Today, health care costs in Canada are increasing at a faster rate than government revenue, and the scramble by governments to find more money for health care is resulting in the neglect or severe underfunding of other critical priorities.

Eventually this scenario will lead to a crisis, and crisis decision-making, I know from sad experience, is not good decision-making. I was one of the finance ministers in the 1990s who had to make difficult, even painful, decisions to cut programs and increase taxes to deal with the fiscal crisis. By 1993 Saskatchewan and other provinces had such dismal credit ratings that they could not borrow money in Canada, and interest on the national debt was growing by more than $100 million a day. The 1990s fiscal crisis could have been avoided if governments had heeded the warnings that the arithmetic of deficit financing was unsustainable. Today, governments are dancing around the fiscal realities of the health care system, sometimes aided by experts who dismiss health care's *fiscal problems*, as was the case with the deficit in the 1990s. Indeed, in 2001 a prominent Canadian economist compared the 1990s fiscal situation with the current debate on health care: "Are those of us, today, who argue that the current [health care] regime is sustainable and manageable, the very same types of people who, years ago, thought that somehow we would manage our way through our fiscal problems without making major structural change? Unfortunately, I think this is closer to the truth than I really like to believe."[1] Do we have to reach another crisis, either in the health care system or because of the unwise trade-offs being made to fund health care, before we act?

The ground won in eliminating deficits in the 1990s is being lost at the provincial level as governments return to deficit financing. Provincial deficits jumped from $1.8 billion in 2002-03 to $5.0 billion in 2003-04,[2] and some provinces are recording balanced budgets only because they are draining reserves or making one-time asset sales. While revenue problems, such as costly tax cuts in Ontario or the effects of SARS and the higher dollar, account for some of the fiscal trouble, the main cost driver for provincial budgets is health care.

Long-term Sustainability of the Health Care System

What is the best way to measure the cost of the health care system? If we compare total health care costs to the size of the economy (GDP), Canada's spending on

health care is among the highest in the world. It increased from 7 percent of GDP in 1975 to 9.8 percent in 2002 and is forecast to reach 10 percent by 2003, which works out to $3,839 each year for every man, woman and child in Canada.[3]

But costs relative to GDP are not a reliable way to measure the affordability of the health care system. This measure omits key costs, such as the cost of the accumulated deficits and debts of hospitals and health boards, and the cost of replacing outdated equipment and facilities that deteriorated during the 1990s — in Ontario alone these costs have been estimated to be almost $10 billion. Also, government revenue does not necessarily increase at the same rate as GDP. According to the Conference Board of Canada, "the overall share of government revenues relative to GDP is expected to decline over the next 20 years," partly because of the changing spending patterns of an aging population.[4] The only reliable way to measure affordability is to compare the costs of health care with the actual revenue that governments have to spend and to consider how much of the government spending pie is devoted to health care.

The main fiscal problem with health care is that its costs are rising faster than the revenue of any government in Canada. Let us take Ontario as an example. Between 1997-98 and 2002-03 the Ontario government increased its health care spending by 42 percent, while its revenue base increased by only 31 percent. Between 1997-98 and 2003-04 health spending increased at an average rate of 8 percent a year, while other spending increased by only about 4 percent. Because health spending is growing at a faster rate than government revenue, it is consuming a larger and larger share of the public spending pie. From the 1980s until 1994-95 health care accounted for about 32 percent of all Ontario government spending, but by 2003-04 it accounted for 39 percent. Moreover, if interest costs are omitted, then 46 percent of Ontario program spending goes to health care.[5]

The problem of rising health care costs also has to be considered from the perspective of demography. A recent comparison of Organization for Economic Co-operation and Development (OECD) countries found that "from a fiscal point of view, Canada's demographic profile is currently as favourable as it has been for a generation and more favourable than it will be for at least another fifty years." With the baby boomers in their forties and fifties, "the number of people paying taxes relative to the number drawing pensions or drawing heavily on the health-care system is close to its peak."[6] When the oldest baby boomers reach 65 in 2012, not only will many have left the workforce, but they will also incur more health care costs since about 50 percent of a person's health care costs are incurred after the age of 65,[7] a trend that will accelerate as the baby boomers age — by 2026 all of the baby boomers will be over 65. While other OECD countries have responded to the challenges of an aging popu-

lation by taking action to make services like health care more affordable in the long term, Canada — with the exception of changes to the Canada Pension Plan — has not addressed the affordability of age-related services like health care. As a result, the unfunded liability of Canada's age-related programs is estimated to be 300 percent of GDP, well above that of the United States at 200 percent, Germany at 150 percent and Britain at less than 100 percent.[8] Thus, if we are struggling to pay for health care today, with a very favourable demographic profile, how do we propose to fund the system as the baby boomers age and problems like labour shortages become more pressing?

Warnings about the long-term sustainability of the health care system have been sounded in government-commissioned reports. For example, Kenneth J. Fyke, who was commissioned by Premier Roy Romanow to assess Saskatchewan's health care system, wrote in his 2001 report:

> *It is important to remember that health costs are increasing at a rate faster than general government revenue. Should current trends continue, future health expenditures will exceed available resources by a significant and substantial amount. The historical practice of increasing health expenditures at the expense of other important public services is not a feasible, practical or advisable approach.*[9]

Crowding Out Other Priorities

The provinces have known since the late 1990s that health care costs are rising at the expense of funding for other critical priorities. Instead of laying the basic arithmetic of health care costs before voters and proposing dramatic changes, the provinces have adopted two strategies to deal with the situation: squeezing everything else, and pressuring Ottawa to increase its transfer payments to the provinces. First, in the late 1990s, after most of them had balanced their budgets and had money for re-investment, the provinces overlooked the fact that all areas had been cut and invested most of the new monies in health care. Between 1999-2000 and 2001-02, for example, 59 percent of all new provincial spending went to health care.[10] If present spending trends continue, it is projected that by 2020 public spending on health care will outpace other spending by a 2:1 ratio and spending on other goods and services, in real per capita terms, will be below pre-1990-91 recession levels. Funding for highways has suffered, cities have been underfunded and education has been seriously squeezed.

While the share of health spending has been increasing relative to GDP, the funding of education has been declining — from a high of 8.1 percent of GDP in 1970 to a projected 5 percent in 2010. In a knowledge economy an educated, skilled workforce is key. Yet, it is estimated that more than 40 percent of

Canadian adults have inadequate literacy skills, that about 70 percent of Aboriginal people drop out of high school and that, while only 6 percent of jobs are open to those without a high-school diploma, 18 percent of Canadians will not graduate from high school.[11]

While we are preoccupied with the possibility of two-tiered health care coming in the front door, two-tiered education is slipping in the back door. Between 1980 and 2002, while American governments increased per-student support for universities by 30 percent, Canadian governments reduced their support by 20 percent. Increasingly, the costs of education are being shifted from government — the public purse — to students.[12] (Also being shifted to young people is the long-term burden of paying interest on the huge public debt accumulated, mainly in the 1970s and 1980s, by programs from which they did not even benefit.) The shift in the costs of education to students takes the form of higher tuition and increased debt loads. Increasingly, education is described as a private good — a wise investment that primarily benefits the individual. But education is also a public good, especially in the twenty-first-century knowledge economy in which the vast majority of new jobs will require advanced education and training.

Since returning part-time to the university in 2001 after a 10-year political leave, I have been struck by the dire financial straits of some students and the disparity between students whose tuition is paid and those who have to work long hours in order to pay for it themselves. The latter often have to settle for fewer classes or take a whole year off to work and save money, so that it takes them longer to get their degrees. Also, those juggling work and study often lack the time needed to get into the top rung of marks, which means that while they may earn a first degree they cannot easily achieve the grades required for an advanced degree. High debt loads also affect job choices, since heavily indebted graduates often have to opt for the job that pays the most rather than one that is more rewarding — an interesting question is the extent to which such financial pressures lure students to high-paying jobs in other countries, particularly the United States. While publicly funded, universal health care may be a defining feature of Canada, so is the equality of opportunity that comes with access to education, and this is in jeopardy.

From my experience at the cabinet table, I know there are political reasons why health care always wins out in a contest with education. While underfunding of health care becomes manifest in visible crises — overcrowded emergency rooms, bed shortages or long waiting lists — assessing the quality of and access to education is more complex. Also, seniors, who are the greatest users of health care, are more likely to be organized and to vote — and irate seniors can strike terror into the hearts of politicians. On the other hand, voting has declined in Canada since the 1988 federal election and young people represent one of the

largest groups of nonvoters. In the 2000 federal election only about one quarter of those under 25 who were eligible to vote actually did so. Whether overburdened with work or alienated from the political process, students lack the political clout to press the case for better funding of education, even though polls show that Canadians would give them a sympathetic ear on this issue.

The extent to which health care is squeezing out funding for education and other priorities can be seen by considering Ontario's options for its 2004 budget consultations. The Ontario finance ministry estimated that the budget could be balanced by 2006-07 if spending increases were limited to 2.3 percent a year for three years. The task would be reasonably simple were it not for the fact that health care spending increases by 8 percent a year and represents 46 percent of Ontario's program spending, which leads to the following possible scenarios (see table 1).[10]

- If program spending can increase by only 2.3 percent a year and health care spending continues to grow at a rate of 8 percent per year, then everything else, including education, has to be cut by an average of 2.9 percent a year for three years — a total cut of 8.4 percent.
- If program spending can increase by only 2.3 percent, health care spending continues to increase 8 percent and education (which represents 22 percent of the budget) receives a 5-percent increase, then other spending has to be cut by about 8.9 percent per year on average, which is more than 24 percent over three years — a virtually impossible task.
- If program spending can increase by only 2.3 percent, education receives a modest 3-percent increase and all other costs are frozen for three years, then the annual rate of growth in health spending has to be reduced to 3.6 percent — an annual reduction of 4.4 percentage points, or almost 12 percent after three years.

Ontario Premier Dalton McGuinty depicted the arithmetic of health care costs when he noted the rate of increase in health care spending and concluded: "At these rates, there will come a time when the Ministry of Health is the only Ministry we can afford to have and we still won't be able to afford the Ministry of Health."[11] In short, to balance its budget Ontario has to either reduce the amount of public money spent on health care or squeeze spending for other priorities, including education.

The trade-offs are reflected in the 2004 provincial budgets. In Ontario, the government increased spending on education and training by 8.3 percent and limited the rate of increase in health care spending to 5.5 percent and overall program spending to 6.7 percent in 2004-05. However, between 2004-05 and 2007-08 it will reduce program spending dramatically, to 1.9 percent, and limit health care spending to increases of 3.4 percent on average for the next three fiscal years.[12] Meeting these targets will be a challenge; however, as Canada's largest province,

Table 1
Ontario Budget Scenarios, Base Year 2003-04 ($ millions)

a) Scenario 1

	Program spending (2.3%)	Health (8%)	Other spending	Other spending reduction (%)
Base year	62.518.0	28.100.0	34.418.0	n/a
Year 1	63.955.9	30.348.0	33.607.9	-2.35
Year 2	65.426.9	32.775.8	32.651.1	-2.85
Year 3	66.931.7	35.397.9	31.533.8	-3.42
Average				-2.87

b) Scenario 2

	Program spending (2.3%)	Health (8%)	Education (5%)	Other spending	Other spending reduction (%)
Base year	62.518.0	28.100.0	13.688.0	20.730.0	n/a
Year 1	63.955.9	30.348.0	14.372.4	19.235.5	-7.21
Year 2	65.426.9	32.775.8	15.091.0	17.560.0	-8.71
Year 3	66.931.7	35.397.9	15.845.5	15.688.2	-10.66
Average					-8.86

c) Scenario 3

	Program spending (2.3%)	Health	Education (3%)	Other spending (0%)	Health spending growth rate (%)
Base year	62.518.0	28.100.0	13.688.0	20.730.0	n/a
Year 1	63.955.9	29.127.2	14.098.6	20.730.0	3.66
Year 2	65.426.9	30.175.3	14.521.6	20.730.0	3.60
Year 3	66.931.7	31.244.4	14.957.2	20.730.0	3.54
Average					3.60

Source: Calculated by the author using data from the Hon. Greg Sorbara, *2004 Ontario Budget: The Plan for Change* (Toronto: Queen's Printer for Ontario, 2004).
Note: The base year spending estimates are for 2003-04 as reported in *2004 Ontario Budget*, p. 38.

Ontario could serve as a model for the rest of Canada for controlling health care costs in the interests of adequately funding other critical priorities like education.

Ontario, however, was the exception. In other provinces the lion's share of new money went to health care at the expense of adequate funding for other priorities. In Saskatchewan, for example, 72 percent of all new money went to health care. Being squeezed out were education, highways, infrastructure,

research and a competitive tax regime, all of which are critical in fostering a competitive economy that will produce the taxpayers of the future to pay the costs of health care and other services for the aging baby boomers.

Federal-Provincial Fiscal Relations

The second provincial strategy for meeting higher health care costs has been to pressure the federal government to increase its transfer payments to the provinces. The provinces argue that Ottawa has been pulling back from its commitment in 1966, when medicare was established, to share health care costs with the provinces.[16] It is true that since 1971 the federal government, concerned about the affordability of health care, has been reducing its commitments. By 1994 federal cash contributions paid for only 16 percent of provincial health care costs.[17] From 1995-96 to 1997-98 the federal budgets reduced cash transfers to the provinces from $18.5 to $12.5 billion.

However, in the last five years the federal government has made substantial investments in health care. In support of the 2003 Health Accord, it committed an additional $36.8 billion, including the $2 billion announced in January of that year. This funding built on the $23.4 billion provided in support of the 2000 Health Accord. In total, the federal government has committed $65 billion in new health funding in the last five years.[18] To put these numbers in perspective, the federal government spends about $8.4 billion a year to address child poverty through the Canada Child Tax Benefit, including the National Child Benefit initiative. What these commitments mean is that over the next eight years federal spending on health care will increase by an average of 6.65 percent a year, higher than the growth in either the economy or government revenue.[19] Such enormous investments have not significantly increased the federal share of health care costs because the costs of the system are rising dramatically.

Despite all of this new money, a recent study by the economists Paul Boothe and Mary Carson illustrates, by means of a simple example, the implications of the mismatch between the growth of health care costs and the growth of government revenues. Based on rough approximations of the current Canadian reality — an $80-billion public health system growing at a rate of 7 percent per year on average and government revenues (including federal transfers) growing at 5 percent — the authors show a funding gap of over $10 billion after five years. That works out to $330 per person, or $1,320 for a family of four, and this money will have to be found by cutting programs or raising taxes. And the problem gets progressively worse every year as a result of compounding: thus, by year six the funding gap will

have increased to $12.9 billion and by year seven to $15.9 billion. Since the federal contribution is proportionally small (14 percent), even increasing transfers by 7 percent per year would only narrow the gap to $300 per person.

Boothe and Carson's study highlights the basic arithmetic of health care: because health care costs are increasing faster than government revenue, spending on health care will eventually crowd out spending on all other priorities and consume 100 percent of all new monies. This is a looming crisis, with the only question being whether it will be manifested as a health care crisis or as a crisis of underfunding, in terms of other public priorities.

Instead of addressing the arithmetic of health care, both levels of government have engaged in finger pointing. The provinces and territories say that federal transfer payments should increase. To bolster their case they commissioned a Conference Board of Canada study that they use to argue that there is a fiscal imbalance between the provinces, which have expensive spending responsibilities like health care, and the federal government, which has more revenue-raising capacity and a future of budget surpluses. The Conference Board study projects that by 2019-20 the federal government will have accumulated surpluses of $78 billion, while the provinces will have more than $11 billion in deficits. However, the study rests on some debatable assumptions.

First, the study fails to consider the implications of its assumption that health care spending will have to increase by 5.2 percent a year just to maintain the current system while provincial revenue is projected to increase by only 4 percent a year.[20] Since health care represents 41 percent of provincial budget spending,[21] it should come as no surprise that health care costs are driving the provinces into deficit. If the model assumed that health care spending increased at the same rate as spending on education, social services and other programs, then the provinces would have surpluses of more than $60 billion by 2019-20. Rather than drawing conclusions about what the model says about federal-provincial fiscal relations, the study should have concluded that when the cost of a critical service increases at a faster rate than government revenue, whichever government is primarily responsible for that service will end up in deficit.

Second, a key assumption is that all of the new health care costs will be borne by the existing public purse, not by new taxes or charges for health care, even though some provinces have instituted revenue measures to help pay for health care. Health care costs are driving provinces into deficit; however, provinces also have the fiscal power to institute health care premiums or other tax measures to cover these increasing costs.

Third, the projected federal surpluses also rest on the assumption that for the next 17 years there will be no new federal spending initiatives or new federal tax

cuts and all federal surpluses will be used to reduce debt. As the authors concede, it is the accelerated rate of debt reduction — which rests solely on the assumption that there will be no new federal spending or tax initiatives — that accounts for the large federal surpluses. In other words, if one does not accept the assumption that Ottawa should turn its back on new spending initiatives or tax cuts until 2019-20, then there will be no accelerated debt repayment and the enormous federal surpluses will evaporate and not be available for redistribution to the provinces.

The Trade-offs Inherent in the Current System

What the Conference Board study shares with other studies on federal-provincial relations and the Romanow report on health care is a failure to take account of trade-offs. What are the implications for other government priorities of devoting such a high percentage of public resources to one priority? For instance, the Conference Board projection builds into its model an automatic 5.2-percent annual increase in health care spending, which it assumes will come out of the public purse, and by assuming that there will be no new federal spending or tax reduction initiatives for 17 years. Similarly, studies on the intergovernmental aspects of health care develop models based on concepts like historical contributions or equity considerations to determine the percentage of health care costs that should be paid by Ottawa. Omitted from such models is a fundamental question: What would committing the federal government to paying 20 to 25 percent of health care costs, when such costs are increasing faster than government revenue, mean for the funding of other priorities?

In a similar vein, the most glaring weakness of the Romanow report is its failure to consider trade-offs. Other reports carefully analyze the trade-offs involved in committing such a high percentage of new funds to health care and recommend alternative funding vehicles to address the problem.[22] The Romanow report, in contrast, recommends that the federal government commit to an escalator that would increase its funding to health care at a multiple of 1.25 of the growth in the economy, and it suggests no new taxes or other ways to pay for these increasing contributions.[23] Since the rate of increase in federal health care funding would exceed the rate of increase in federal revenue, the result would be a decline in funding for other national priorities, as has occurred at the provincial level.

What are the trade-offs inherent in squeezing out funding for other priorities? What role should the federal government play in a twenty-first-century Canadian economy and society? Comparing the 1970s and today in terms of the federal capacity to contribute to health care costs is like comparing apples and oranges. In the 1970s the federal government had little debt and minimal interest payments and was

not paying its bills (running deficits); today it pays more than $35 billion a year in interest (on the debt racked up primarily in the 1970s and 1980s). Also, it has responsibilities that were unheard of in the 1970s or even a decade ago. The National Child Benefit is a new program introduced in the 1990s to help tackle child poverty and allow families to move from welfare to work without the loss of family income or other health care benefits for their children. The program is fully funded by the federal government, and although it has had some success in reducing child poverty, Canadian poverty rates are still high. It is important that Ottawa expand its social programming to continue to address poverty, especially since poverty is often more prevalent in poorer provinces or territories that lack the resources to deal effectively with the problem. For example, the recent federal budget's Learning Bonds to help low-income families finance advanced education for their children is an important but modest first step; new federal spending initiatives like this will be required in the future.

Another new federal program, initiated in the 1990s, is the Innovation Strategy. Laboratories, synchrotrons and other research facilities are the infrastructure of the twenty-first-century economy, just as railways and canals were the foundations for the economy of the nineteenth and early twentieth centuries. Through the Innovation Strategy, the federal government has made critical investments in the building and operation of such facilities and in the commercialization of their research. Canada has consistently lagged behind other OECD countries in its investments in research, resulting in lower levels of productivity. Why should this matter to Canadians? Higher productivity leads to higher income levels, which in turn means that governments have a growing tax base from which to pay for health care and other public services.

The Innovation Strategy also involves upgrading the skills and education of Canadians so that we can compete in the knowledge economy and prepare for the labour shortages that loom in the next decade with the retirement of the baby boomers. By 2011, the number of Canadians entering the work force will be almost exactly equal to the number leaving it, which means that Canada can increase its workforce only through immigration. However, while we are trying to attract more immigrants to Canada, other Western countries, facing similar demographic challenges, will be trying to lure away our best and brightest. For example, in the next 12 years, universities will have to hire 30,000 new faculty to replace retirees, but there are not enough graduate students in the system to fill the gap and one in eight doctoral students now leaves Canada for the United States. According to a recent government study, "Canada will have great difficulty becoming more competitive without a greater number of highly qualified people to drive the innovation process and apply innovations, including new technologies."[21] Finding these "highly qualified people" will require investments in upgrading the skills of Canadians and in

pursuing more skilled immigrants. Canada is engaged in an international competition for educated, skilled people, and what will be required to attract and retain such people should be a critical issue in public policy decision-making. Since immigration is a key part of the solution, federal involvement will be necessary.

The environment is another issue that was not on the public policy agenda in the 1970s but will require new federal investments in the future. It has been estimated, for example, that implementation of the Kyoto Accord will cost $8.1 billion per year between 2004 and 2015.[25]

A broad area that is exclusively in the federal domain and will require significant new investments encompasses border security, defence and foreign aid. Canada has the longest coastline in the world and the second-largest land mass, yet its spending on the military is among the lowest in NATO. Also, despite its wealth and good fortune, Canada's foreign aid contributions place it third-last among OECD countries. And the 9/11 crisis and its aftermath have highlighted the importance of enhancing the security of our borders with the United States. Billions of dollars of new federal investments will be required over the next decade to equip Canada to play a meaningful role in the world and ensure its security.[26]

As well as taking into account the other federal priorities that require funding, any discussion of the fiscal imbalance and Ottawa's capacity to continue investing heavily in health care has to consider the arguments made by municipalities to the effect that there are three levels of government in Canada, not two. While municipalities are constitutionally entities of the provinces, in the twenty-first century the majority of Canadians are city-dwellers and cities are the centres of economic activity and competition. Companies or individuals rarely choose between locating in Ontario and Illinois; instead, they compare the amenities and costs of Toronto and Chicago. Also, cities are coping with social challenges that include poverty, homelessness, and the integration of immigrants and Aboriginal people who are migrating to western Canadian cities in increasing numbers. At the same time, cities are struggling to upgrade crumbling infrastructure, whose costs have been estimated to exceed $50 billion,[27] with the limited revenue tools of property taxes and user fees. Any assessment of a fiscal imbalance between the various levels of government in Canada would have to consider the case being made by municipalities.

Provincial Demands on the Federal Purse

There are, then, many critical priorities, beyond increasing transfer payments to the provinces to pay for programs like health care, that have a legitimate claim to a share of federal revenue. This is especially important when one considers how

much of the federal spending pie the provinces and territories are requesting. In its 2004-05 budget the Quebec government laid out its case for increasing federal transfers to provincial and territorial governments and specified the new money being requested between 2004-05 and 2009-10.[28] The increased funding includes more money each year in federal transfer payments for health, education and social programs, and for equalization. The magnitude of what the Quebec government is seeking can be seen by comparing the total amount requested with the federal surpluses available, according to the Conference Board of Canada study commissioned by the provinces (see table 2).

In year one the additional federal transfers that Quebec is requesting amount to about 70 percent of federal surpluses — $7.2 billion of a total of $10.1 billion. In year two they make up almost 100 percent of federal surpluses. From years three to six the amounts are significantly more than the federal surpluses. In fact, by 2009-10, if the federal government agreed to the provincial/territorial proposal, it would have an accumulated deficit of more than $24 billion. Also, agreeing to Quebec's request would mean that over a six-year period there would be no federal money for new spending or tax reductions. It has to be remembered that the projected federal surpluses that form the basis for this comparison come not from the government of Canada but from a study *commissioned by the provinces and territories.*

Table 2
Impact of Quebec Proposals on Federal Budgetary Balances ($ millions)

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10
Provincial Equalization proposal	5,212	5,461	5,703	5,957	6,226	6,505
Provincial health/social transfer proposal	2,000	3,471	6,570	9,018	12,116	15,390
Total transfer increases	7,212	8,932	12,273	14,975	18,342	21,895
Cumulative	7,212	16,144	28,417	43,392	61,734	83,629
Government of Canada surplus	10,065	9,791	8,574	7,910	9,620	12,854
Cumulative	10,065	19,856	28,430	36,340	45,960	58,814
Federal surplus (deficit) left for other federal spending	2,853	859	(3,699)	(7,065)	(8,722)	(9,041)
Cumulative	2,853	3,712	13	(7,052)	(15,774)	(24,815)

Source: Government of Quebec, "Correct the Fiscal Imbalance," *Budget 2004-2005* (Quebec City, 2004), p. 31; and The Conference Board of Canada, *Fiscal Prospects for the Federal and Provincial/Territorial Governments* (Ottawa: March 2004), table 2B.

While the provinces can be faulted for making unrealistic demands on the federal public purse, the federal government is guilty of investing in health care like a "bondholder" but acting like an "equity shareholder," to use the colourful language of Claude Forget.[29] No matter how much more money Ottawa invests in health care, the vast majority of health care funding will come from the provinces, which also have the constitutional responsibility to run the system — which means facing the day-to-day criticism of Canadian voters. As the provinces struggle to fund an overburdened system, Ottawa consistently tells them how federal funds should be spent and even advocates that an already overburdened system be enhanced through improved coverage for home care and prescription drugs. The mantra is "buying change," which means more spending on preventative measures and on reforms like primary health care. However, the changes involved in the debate so far will not fundamentally "change" the arithmetic of a system whose costs are increasing at a faster rate than government revenue.

Many English-speaking Canadians like the idea of a pan-Canadian health care system with national standards imposed by a federal government enforcing The Canada *Health Act*. Yet, the most federalist Quebec government in recent history has been absolutely clear about its position. In April 2004 Quebec Intergovernmental Affairs Minister Benoît Pelletier said, "We want Ottawa to fully recognize that Quebec has full jurisdiction over the planning and management of the health-care system...We are willing to pursue some common objectives but we will never discuss national standards that could jeopardize our authority over health care."[30]

Alberta has been equally clear that since the federal government neither runs the system nor pays the majority of its costs, it should not be imposing national standards for health care on Alberta. Alberta has also suggested that if Ottawa were to challenge any changes that the province made to its system by enforcing the financial penalties in *The Canada Health Act*, the province might simply opt out of the restrictions in the Act, thereby foregoing the federal funding at stake.

In terms of fiscal capacity, Alberta could make good on its threat. While all other Canadian governments are burdened with debt and high interest costs — Ontario pays about $10 billion a year in interest on its net debt[31] — Alberta is effectively debt-free, meaning that it has growing surpluses available to spend. The issue is a simple one: How can the federal government establish national standards for health care when its second-largest province and its wealthiest province are not willing to participate? An alternative would be to follow the example of the European Union, where environmental and fiscal standards have been established by the member states themselves.

While the two levels of government debate how much each should contribute to health care and who should establish and enforce standards,

governments avoid confronting the emerging fiscal crisis in the system and seldom objectively assess the quality and effectiveness of Canadian health care. Because the costs of health care are increasing at a faster rate than the revenue of any government, the provinces have been able to fund the system only by deficit financing, squeezing funding for other priorities and pressuring Ottawa to increase its transfers to the provinces. Now the federal government is increasing its own funding for health care at a faster rate than its revenue is growing and is spending the vast majority of its surpluses on health care.

The Cost-effectiveness of the Current System

What are Canadians getting for all the money being spent on health care? Recently, the Conference Board of Canada compared the cost and effectiveness of health care in 24 OECD countries. It found that Canada was the third-largest spender on health care. At the same time, "waiting times [for medical treatment] are already among the highest in OECD countries." And in terms of the health status of Canadians, we rank only 13th of 24 countries.[32] Canada's ranking shows that rather than seeing our health care system as a model for others, we should consider what we might learn from other countries outside North America.

Debates about change in Canada have to go beyond merely comparing ourselves to the Americans, who have one of the most expensive and least equitable health care systems in the developed world, and beyond the standard rhetoric that too often accompanies discussions of health care in Canada. Champions of the status quo have been very effective at branding new ideas about health care as taking Canada down the road of an Americanized, privatized, two-tiered system that will undermine the fundamental principles of medicare. Yet preserving the fundamental goals of medicare will require changing the system to adapt to new circumstances and asking basic questions about its effectiveness. Why are Western European countries achieving better health results while spending less on health care? What were the original goals of medicare, when it was created more than 40 years ago by Saskatchewan's Premier Tommy Douglas, and what has changed since that time?

The Conference Board study reveals some of the reasons why European countries like Sweden outperform Canada. It demonstrates that spending more money on health care can actually lead to a less healthy population, because of the trade-offs — underfunding of other priorities that are critical to good health. According to the study, only about 25 percent of a person's health status depends on the health care system, while 50 percent is related to living conditions — factors such as income level, education and environment.[33] Sweden has the least expensive health care system of all the

OECD countries while enjoying the second-highest health status and low poverty levels. In contrast, in a recent comparison of 20 OECD countries, Canada ranked a poor 13th in terms of poverty levels[31] — a key contributor to ill health. In Canada the poor are treated equally when they become ill, with full access to the health care system, but this does not help to alleviate poverty. Devoting more resources to tackling poverty — investing in early childhood education, housing, better training programs — would lead to healthier Canadians and reduce the cost to the health care system. This is but one example of how devoting so much of our public investments to health care means that there are not enough funds left over to invest in preventative measures that would both promote health and reduce health care costs.

Improving Incentives and Equity through New Funding Mechanisms

When Tommy Douglas introduced medicare in Saskatchewan, his vision was that people would have access to the health care that they need regardless of their financial circumstances, a principle that should be preserved and should underpin all discussions about the future of health care. But there are principles that should be reconsidered in light of today's realities. For example, medicare was created as a form of social insurance. As Keith Banting and Robin Boadway recently explained, "the central proposition is that, in a humane society, persons ought to be compensated for differences in their risk of ill health over which they have no control."[35] But what about today, when many health problems are not beyond patients' control but are in fact directly related to lifestyle choices? Even when there is clear evidence that certain lifestyle choices contribute to ill health, some people continue to make those choices, and there are no incentives in our health care system to encourage them to make better ones.

In the 1990s, during my brief stint as Saskatchewan minister of social services, I participated in the evolution in thinking about social policy when welfare and unemployment insurance were reformed to incorporate the ideal of co-responsibility, the idea that recipients of benefits have to take an active role in addressing their problems. Rather than accepting the idea that welfare and unemployment insurance are entitlements — government programs that require no effort on the part of recipients — we built incentives and supports into the social programs to encourage people to move from welfare or unemployment to work. Similar new thinking has not occurred in health care. Thus, there are no incentives in our health care system for people to take more responsibility for their own health and address

lifestyle choices that lead to ill health. It is time that this changed. Tommy Douglas's original vision of medicare would not be compromised by changing the system to encourage people to take more responsibility for their own health.

Other changes, beyond those to which all governments in Canada subscribe — more prevention, accountability and transparency, and reform of primary health care — will be required to make the health care system affordable and effective. Governments also need to consider the effects of technology — new treatments, equipment, procedures and drugs — on the ever-growing demand for health care services. Putting parameters around demand will require a federal-provincial/territorial discussion about what should and should not be covered by *The Canada Health Act*.

Also, one of the reasons for long waiting lists and other forms of rationing in the Canadian system is that we have open-ended parameters for demand. Sweden has small to non-existent waiting lists, in part because it handles demand differently and expects patients to share more responsibility for their health care choices. Can we learn anything from Swedish policies? Sweden can more easily put parameters around demand because, like virtually every other Western European country, it has a parallel private system. Yet, in most European countries the private system remains small and does not crowd out or threaten the public system. Why is this the case?

Although in theory Canada has a single-tiered health care system where all wait their turn, is this the reality? Do we really believe that wealthy Canadians are waiting their turn for medical procedures instead of going elsewhere and paying for the best of care on a timely basis? Even within the country, how many average Canadians in provinces like Saskatchewan travel to another province, such as Alberta, where they can pay for immediate diagnostic services delivered using the most up-to-date equipment?

An open-minded assessment of ways in which to change the Canadian health care system should be part of efforts to close the gap between the rate at which health care costs are increasing and that at which government revenues are increasing. But with an aging population and the ongoing development of new technologies, changing the system will not by itself close the gap. What is also required is a new way to fund health care.

Right now the debate on health care financing is stalled, since the focus is on the amount that Ottawa should contribute to the system. Thus, we need to establish the federal contribution and the rate at which it will increase instead of continuing with an ad hoc approach to funding. In determining the federal contribution, it is critical that enough federal resources remain to fund other priorities. This means that if the federal government agrees to an escalator (an estab-

lished formula to increase funding), then federal funding for health should only increase at the rate of increase in federal revenue.

It would be a serious mistake to commit the federal government to pay an established share of health care costs. First, such a commitment would merely take the federal government down the road travelled by the provinces, of squeezing funding for other critical priorities. Second, it would be bad public policy to have provincial governments administering health care and Ottawa committed to paying a fixed percentage of its costs without having a role in running the system and ensuring that it is cost-effective. The flaws in establishing a fixed federal cost-sharing formula were revealed in the 1980s when welfare costs were shared: Ontario and other provinces dramatically increased welfare rates, leaving the federal government to pay its share of the costs without having a role in administering the system.

What is overlooked, however, is the fact that even if the federal government contributed 100 percent of its surpluses to health care, the fiscal problems of the system would not be solved as long as the costs of health care increase faster than government revenue. Even with increased federal funding, the provinces will have to consider new ways to pay for health care so that the system is properly funded and enough public money is available for other government priorities.

The idea of people contributing directly to health care costs is not new. Tommy Douglas did not believe that health care should be cost-free to individuals, and throughout his term as premier Saskatchewan had a health care premium. Recent reports on health care that consider the trade-offs — notably the report of a Senate committee headed by Senator Michael Kirby and the Mazankowski report commissioned by the Alberta government — conclude that sustaining the Canadian health care system requires finding new ways to pay for it. In its report, the Senate committee "categorically rejects the position that the problems of Canada's health care system can be solved in a way that is cost-free to individuals."[30]

In fact, the provinces are already introducing new revenue measures to pay for rising health care costs. Provinces across Canada are increasing fees for a whole range of services; Saskatchewan has increased its sales tax to help cover its health care costs; and Ontario has re-introduced a health care premium, tied to income. One way or another, Canadians are going to pay more for health care. The only question is what is the best way for them to do so, a way that is fair and provides long-term, stable funding for health care while at the same time preserving the principles of medicare.

To be effective, any new provincial revenue measure to pay for health care should have several basic characteristics. First, the tax or premium must increase as the cost of the health care system increases. In the short term, a fixed-rate revenue measure may cover growing health care costs; in the long term, however, as health costs continue to increase at a faster rate than government revenue, other

priorities will be squeezed in the bid to cover health care costs. For example, a variable health care premium could increase at a rate equal to the difference in health care costs and government revenue: If government revenue increased by 4 percent but health care costs went up by 5.5 percent, then the variable health care premium would increase by 1.5 percent.

Second, any new revenue measure has to be fair. It must be related to income and ability to pay. Also, the amount charged must be capped at a certain percentage of income so that no one suffers financial hardship in order to pay for health care.

Third, any new revenue measure should not be levied at the point of service. The Canada Health Act explicitly forbids such fees on the legitimate grounds that charging for health services at the point when they are needed can deter people from seeking necessary medical care. Instead, the charge should be assessed annually in the form of a health care premium or as part of the income tax system.

Finally, even though fees should not be levied at the point of service, the amount that individuals pay for health care should be related to their use of the system, with capping at a certain percentage of income and with provisions to ensure that those with high health care costs are protected from financial hardship. Currently, Canadians have no awareness of the high cost of the health care system or the comparative cost of choosing one type of service over another — such as choosing a hospital emergency unit over a medical clinic. It is reasonable to expect Canadians to assume some of the responsibility for making wise health care choices and to be provided with a financial incentive to do so.

There are also demographic and public policy reasons for linking an individual's payment to his or her use of the health care system. As the baby boomers age and increase their use of health services, it will be important to tap into their incomes to pay rising health care costs. The alternative is to have young taxpayers pay more for health services that are being used primarily by older Canadians.

One issue is intergenerational equity. These same young people are already consigned to a future of paying interest on the debt racked up for services they do not benefit from; they are expected to shoulder more and more of the burden of their education costs and many will graduate with high debt loads. Is it really fair for baby boomers — and I am one — to further burden these young taxpayers with the cost of their health care?

Fairness aside, the looming shortage of educated, skilled workers will limit Canada's ability to rely on general tax measures to fund health care. In the next decade Canada will be competing internationally for educated, skilled workers, a task that will be made all the more difficult if young taxpayers are saddled with high tax loads to pay for a health care system that is used mainly not by them but by older people.

Thus, health care should be funded through a vehicle that is geared to income, that entails an annual rather than a point-of-service charge and that is tied to use of services but capped at a certain percentage of income.[37] Such a revenue measure could be implemented through the income tax system. Health care services — or some selected ones — could be included as a taxable benefit. Such a charge would be directly related to income and would therefore be much fairer than increases in myriad fees or in sales taxes — measures that do not take account of income or ability to pay; and since it would be capped at a certain percentage of income, it would not cause personal financial hardship. At the same time, tax credits could be used to promote healthy choices such as smoking-cessation or weight-loss programs. The difficulty is not in finding alternative means of funding health care but in persuading Canadians that change is necessary.

Change *is* necessary, and I believe that if Canadians open their minds to real change we can preserve the basic principles and goals of the medicare system that was designed 40 years ago. But accepting bold change will require courage and vision.

One of the greatest threats to medicare is posed by those who cling tenaciously to the status quo and claim they are defending Tommy Douglas's vision of medicare by doing so. Recently in Saskatoon as I concluded a speech about the arithmetic of health care an elderly gentleman approached me and introduced himself as a cabinet minister in Douglas's government when medicare was created. He said:

> *Tommy would be appalled to see what is happening to the costs of health care today. He didn't foresee all the new technology and new demands and what they would do to the costs of health care. He would be especially upset if he knew that health care costs were taking needed money away from education. That was never part of his plan.*

Too often in politics, what we cherish most we inadvertently destroy by believing that protecting something means freezing it in time, when in fact protecting it may require dramatic change. Protecting children, for instance, means encouraging them to grow and adapt to the world in which they have to live. If we are going to save Canada's health care system, we will have to change it, and the sooner we embark on the road to change the smoother the journey will be.

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